

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09258

Reg. Diat. No. 64

1. PLACE OF DEATH:

County Caroline
 City or town Federalburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
New Church - Friendship Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline
 City or town Federalburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. New Church - Friendship Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Albert J. Andrew

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Minnie J. Andrew

6. (c) If alive, give age

- years

7. Birth date of

deceased (mo., day, yr.)

August 11, 1863

8. AGE:

Years 85Months 1Days 0If less than one day
hrs. min.

9. Birthplace

Federalburg, Maryland, R.F.D.
(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

Farm

MOTHER FATHER

12. Name

Thomas Andrew

13. Birthplace

Caroline County, Maryland

14. Maiden name

Louisa Aepf

15. Birthplace

Caroline County, Maryland

16. Informant

Russell E. Andrew

Address

Federalburg, Maryland, R.F.D.

17

Burial
(Burial, cremation, or removal. Which?)Date thereof Sept. 14, 1948
(month) (day) (year)

Cemetery or crematory

First Rest Cemetery

Location

Federalburg, Maryland

18. Funeral director

J. J. Frampton as son

Address

Federalburg, Maryland

19.

September 13, 1948
(Date rec'd by registrar)J. J. Frampton

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1948 at 8 P. M.

21. I CERTIFY that death resulted on the date above stated; that I attended deceased from

Aug 11, 1948 to Sept 11, 1948
and that I last saw him alive on Sept 11, 1948

Immediate cause of death

Arteriosclerosis

DURATION

12 yrs.

Due to

Due to

Other conditions

Arteriosclerosis
Gangrene both lower extremities
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank M. Anderson MD.
Federalburg, Md.
M. D. or other
Date signed 9/12/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09259

Reg. Dist. No. 61

1. PLACE OF DEATH:

County... CecilCity or town... Greenbush
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Steward Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Ind. County... KentCity or town... Steel Pond
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war ... ☒

3. (a) FULL NAME

Sarah B. Bedwell

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Harry J. (deceased)

7. Birth date of deceased (mo., day, yr.)

Dec. 7 - 1860

6. (c) If alive, give age ... years

8. AGE:

Years

Months

Days

If less than one day

87918

... hrs. ... min.

9. Birthplace

Kent Co. Ind.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Wm. H. Baynard

13. Birthplace

Ind.

MOTHER

14. Maiden name

Evelyn Palmatier

15. Birthplace

Ind.

16. Informant

Mrs. E. W. Sterling

Address

Church Hill Ind.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 27, 1948
(month) (day) (year)

Cemetery or crematory

Steel Pond

Location

Steel Pond, Ind.

18. Funeral director

Edgar S. Lane

Address

Church Hill Ind.

19.

(Date signed by registrar)

Sept 27, 1948 L. M. Pippin
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... September 25, 1948 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15, 1948 to Sept. 25, 1948and that I last saw him/her alive on... Sept. 25, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 hrs

Due to

Cerebral Hemorrhage

Due to

Cerebral Hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Blanche H. H. H.

M. D. or other

Address

Greenbush Ind.Date signed... 9-25-48

RECEIVED

OCT 4 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09260

Reg. Dist. No. 4K

1. PLACE OF DEATH:

County Caroline
City or town Federalburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
133 Reliance Avenue
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline
City or town Federalburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 133 Reliance Avenue
(If rural, give LOCATION)
2. (a) If veteran, name war —

3. (a) FULL NAME

John A. Collins

3. (b) Social Security Number

None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Mrs. B. Collins
6. (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) February 24, 1864
8. AGE: Years 84 Months 6 Days 25 If less than one day — hrs. — min.

9. Birthplace Federalburg, Caroline County, Maryland
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Pennsylvania Railroad Employee
12. Name Ennals Collins
13. Birthplace Caroline County, Maryland
14. Maiden name Rachael Prattis
15. Birthplace Caroline County, Maryland

16. Informant Mrs. Cassia J. Roach
Address Federalburg, Maryland
17. Burial Date thereof September 21, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Federal Hill Cemetery
Location Federalburg, Maryland
18. Funeral director J. J. Frampton & Son
Address Federalburg, Maryland
19. Sept. 20, 1948 J. J. Frampton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1948 at 1:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 2, 1947 to Sept. 19, 1948
and that I last saw him alive on Sept. 19, 1948

Immediate cause of death Chronic Myocarditis DURATION 2-3 yrs

Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Hayward T. Webb M. D. or other —
Address Federalburg, Md. Date signed 9/20/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 29 1948

BUREAU Y. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09261

Reg. Dist. No. 68

1. PLACE OF DEATH:

County... Caroline
 City or town... Henderson Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 2 Weeks
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?... X

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Delaware County...
 City or town... Wilmington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 515 Spruce Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war... X

3. (a) FULL NAME

Katie Griffin

3. (b) Social Security Number

X

4. Sex... F 5. Color or race... Col. 6. (a) Single, married, widowed, or divorced... Married
 6. (b) Name of husband or wife... Washington
 7. Birth date of deceased (mo., day, yr.)... Feb. 15, 1880
 6. (c) If alive, give age... 62 years
 8. AGE: Years... 68 Months... 6 Days... 29 If less than one day... hrs. min.

9. Birthplace... Goldsboro, Caroline, Maryland.
 (Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business... X

12. Name... Samuel Brown

13. Birthplace... Maryland

14. Maiden name... Sarah Wolford

15. Birthplace... Maryland

16. Informant... Washington Griffin

Address... 515 Spruce St. Wilmington, Del.

17. Burial... Union Date thereof... 9/15/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Union

Location... Near Goldsboro, Maryland.

18. Funeral director... Raymond B. Rawlings

Address... Greensboro, Maryland

19. Sept. 15, 48 RC Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 13 19 48 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 48 to Sept. 13 19 48
 and that I last saw him alive on Sept. 12 19 48

Immediate cause of death... Cerebral

Due to... Chronic nephritis

Due to... Chronic myocarditis

Other conditions... Chronic myocarditis

(Include pregnancy within 6 months of death)

Major findings of operations... Date of op. ...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... RC Smith M.D. or ...

Address... Greensboro, Md Date signed... Sept 14, 1948

RECEIVED

OCT 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 60

09262

93d

1. PLACE OF DEATH:

County CarolineCity or town Goldsboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Goldsboro
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2(a) If veteran, name war X

3. (a) FULL NAME

George B. Marvel

3. (b) Social Security Number

X

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed6. (b) Name of husband or wife Jennie7. Birth date of deceased (mo., day, yr.) Feb. 10, 1874
6. (c) If alive, give age _____ years8. AGE: Years Months Days If less than one day
74 7 10 _____ hrs. _____ min.9. Birthplace Caroline County, Maryland.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business I12. Name Henry D. Marvel13. Birthplace Delaware14. Maiden name Sarah Slaughter15. Birthplace Delaware16. Informant Mrs. Walter ColeAddress Centerville, Maryland.17. Burial Date thereof 9/23/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory GreensboroLocation Greensboro, Maryland.18. Funeral director Raymond B. RawlingsAddress Greensboro, Maryland.19. 9/22 48 a P Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 19 48 at 4:30 AM21. CERTIFY that death occurred on the date above stated; that I attended deceased from
June 15 19 48 to Sept. 20 19 48
and that I last saw him alive on Sept. 19 19 48Immediate cause of death Cerebral Thrombosis DURATION 6 hrsDue to Cerebral Thrombosis
Cardiovascular Disease

Due to _____

Other conditions Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles D. J. Hearn M. D. 9/21/48Address Greensboro Date signed 9/21/48

RECEIVED

OCT - 5 1948

BUREAU V. S.

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Village or City

FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

HEREBY CERTIFY That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory Secondary

(Signed)

192 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

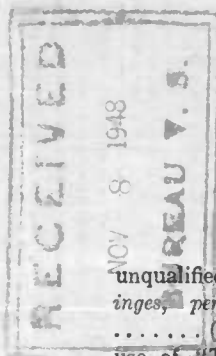
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09264

Reg. Dist. No. 60

1. PLACE OF DEATH:

County Caroline
 City or town Goldsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Caroline
 City or town Goldsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ X

3.(a) FULL NAME

Harvey L. Morris

3.(b) Social Security Number

204-07-1682

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Belle
 7. Birth date of deceased (mo., day, yr.) November 20, 1871
 6.(c) If alive, give age 68 years
 8. AGE: Years 76 Months 9 Days 14 If less than one day _____ hrs. _____ min.
 9. Birthplace Goldsboro, Caroline, Maryland.
 (Town, county, and state)

10. Usual occupation Retired
 11. Industry or business X
 12. Name Edward Morris
 13. Birthplace Maryland
 14. Maiden name ? Diggins
 15. Birthplace Maryland

16. Informant Belle Morris
 Address Goldsboro, Maryland.
 17. Burial Date thereof 9/6/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Greensboro
 Location Greensboro, Maryland.

18. Funeral director Raymond B. Rawlings
 Address Greensboro, Maryland.

19. 9/6 19 48 G. G. Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 19 48 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/3 19 48 to 9/3 19 48
 and that I last saw him alive on 9/3 19 48
 Immediate cause of death Cerebral Hemorrhage

Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE G. G. Smith M.D. or other _____
 Address Goldsboro, Md. signed 9/6-48

RECEIVED

SEP 10 1948

BUREAU V. S.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09265

93d

FILM No. G 117 OCT 26 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:

County Caroline
City or town Hillsboro, Ind.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Marshall County Caroline
City or town Hillsboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

4. Sex M. 5. Color or race Dr. 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec. 8th 1858

8. AGE: Years 89 Months 9 Days 22 If less than one day
hrs. min.

9. Birthplace Hartley, Del.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Joshua Short

13. Birthplace Delaware

14. Maiden name Lina Moore

15. Birthplace Delaware

16. Informant Mrs. Leatha Short

Address Hillsboro, Ind.

17. Buried Date thereof Oct. 2-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenboro Cemetery

Location Greenboro, Marshall

18. Funeral director J. Virgil Smith & Son

Address Denton, Ind.

19. 1942 48 Mr. S. O. George
(Date read by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 19 48 at 12 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 45 to Sept 30 19 48

and that I last saw him alive on Sept. 28 19 48

Immediate cause of death Edema of R. lungs DURATION

Due to Myocardial failure 2 years

Due to Generalized arterio-sclerosis

Other conditions Chronic gall bladder disease

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Ledner M.D.

Address 1011

Date signed 10/1

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT. 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 66

09266

1. PLACE OF DEATH:

County Caroline
 City or town Ridgely
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 Yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline
 City or town Ridgely
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war X

3. (a) FULL NAME

Enoch Strannahan

3. (b) Social Security Number

X

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Margaret
 6. (c) If alive, give age 61 years
 7. Birth date of deceased (mo., day, yr.) February 4, 1886
 8. AGE: Years 62 Months 6 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Gracenville Maryland
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business X
 12. Name John Strannahan
 13. Birthplace Maryland
 14. Maiden name Rebecca Thomas
 15. Birthplace Maryland

18. Informant Royden Strannahan
 Address Ridgely, Maryland
 17. Burial Date thereof 9/ 5/ 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Greensboro
 Location Greensboro, Maryland.
 18. Funeral director Raymond B. Rawlings
 Address Greensboro, Maryland.
 19. Sept. 3 19 48 Harry E. Laird
 (Date fixed by registrar) Registrar

MEDICAL CERTIFICATION

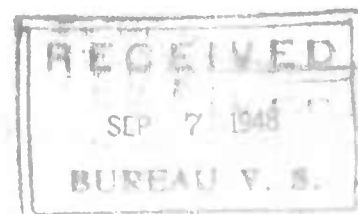
20. DATE OF DEATH Sept. 2 19 48 10:50AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb. 15, 19 47 to Sept. 2 19 48
 and that I last saw him alive on Sept. 2, 19 48

Immediate cause of death Cronary Thrombosis
General Atherosclerosis
 DURATION 18 mos
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Charles H. Strannahan
Greensboro, Md. M.D. or other _____
 Address _____ Date signed 9/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09267

Reg. Diat. No. 62

1. PLACE OF DEATH:

County Caroline
City or town Denton Rural Williston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline
City or town Denton Rural Williston
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sadie M. Thomas

3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Robert W. Thomas
6.(c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) Jan. 18 1883
8. AGE: Year 65 Month 8 Day 12 If less than one day _____ hrs. _____ min.

9. Birthplace Caroline County - Ind
(Town, county, and state)

10. Usual occupation House-work

11. Industry or business Own home

12. Name Thomas Marine

13. Birthplace Caroline County Ind

14. Maiden name Hester Blanche

15. Birthplace Caroline County Ind

16. Informant Robert W. Thomas

Address Denton Ind R. F. D.

17. Burial Date thereof October 3, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Hill-Crest Cemetery

Location Federalburg Ind

18. Funeral director J. J. Thompson & Son

Address Federalburg Ind

19. Oct 2 1948 M. D. George
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30th 1948 at 10⁰⁵ A-M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 1947 to Sept. 30 1948
and that I last saw him alive on September 29 1948

Immediate cause of death myocardial Failure
hypertension
Due to hypertension

Due to _____

Other conditions Diabetes Mellitus
terminal Bronchopneumonia
(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other _____
Address Denton Ind Date signed 10/1/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09268

Reg. Diat. No. 62

1. PLACE OF DEATH:

County Caroline
 City or town Denton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Twenty four years
 Hospital, institution, or street address where death occurred no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline
 City or town Denton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 526 Hay (If rural, give LOCATION) no
 2.(a) If veteran, name war no

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex male 5. Color or race a-a 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife M. Bryant Weaver
 yes yes 6.(c) If alive, give age Don't know years
 T. Birth date of deceased (mo., day, yr.) Oct 8 1894
 8. AGE: Years 53 Months 11 Days 7 If less than one day hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1948 at 11:15 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 17 1927 to Sept. 16 1948
 and that I last saw him alive on Sept. 16 1948
 Immediate cause of death Cerebral Hemorrhage
 DURATION 5 hours
 Due to no
 Due to no
 Other conditions Arteriosclerosis
 (Include pregnancy within 3 months of death)
 Major findings of operations no
 Date of op. no
 Autopsy results no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

9. Birthplace Waco Texas
 (Town, county, and state)
 10. Usual occupation Teacher
 11. Industry or business same as above
 12. Name Rev. E. B. Weaver
 13. Birthplace Waco Texas
 14. Maiden name Mary J. Led Berry
 15. Birthplace Waco Texas
 16. Informant M. Bryant Weaver
 Address Denton md
 17. Burial Date thereof Sept 17-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Low
 Location Marshall's Ohla.
 18. Funeral director James Stewart
 Address Salisbury Md
 19. 9/17 1948 Wm O George
 (Date rec'd by Registrar) Registrar

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide no Date of no
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Injured at work?
 Means of injury no
 23. SIGNATURE E. Paul Knotts M.D. M. D. or other
 Address Denton md Date signed 9/17/48



PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09269

Reg. Dist. No. 60

1. PLACE OF DEATH:

County... Caroline
 City or town... Henderson Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 1 Yr. 11 Mo.
 Hospital, institution, or street address where death occurred:
X
 How long in hospital or institution?... X

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Caroline
 City or town... Henderson Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None

3. (a) FULL NAME

Edward George Woolyhand

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife... X
 7. Birth date of deceased (mo., day, yr.) October 10, 1946
 8. AGE: Years 1 Months 11 Days 16 If less than one day
1 hrs. 16 min.

9. Birthplace... Henderson, Caroline, Md.
 (Town, county, and state)
 10. Usual occupation... None
 11. Industry or business... None

12. Name... Otis Woolyhand
 13. Birthplace... Henderson, Maryland.
 14. Maiden name... Florence Ross
 15. Birthplace... Henderson, Maryland.

16. Informant... Mrs. Florence Ross
 Address... Henderson, Rural, Maryland.
 17. Burial Date thereof... 9/28/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Greensboro.
 Location... Greensboro, Maryland.
 18. Funeral director... Raymond B. Rawlings

Address... Greensboro, Maryland.
 19. 9/27 48 Registrar
 (Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 26 1948, at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 10 1947, to Sept 26 1948
 and that I last saw him alive on Sept 26 1948

Immediate cause of death... Congenital defect of cerebrum.
 DURATION 23 hrs.

Due to... Cause unknown

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Dr. Paul Smith M.D.
 Address... Winston Md. Date signed 9/27/48

RECEIVED

OCT 5 1948

BUREAU V. S.